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ABSTRACT

This report provides an overview of the American Academy of Pediatrics' three-part access to health care campaign. To ensure that legislative action benefits children, the academy has developed a legislative proposal that serves as a benchmark for health reform initiatives. This special report provides an outline of the proposal and describes some families the access campaign is designed to help. An overview is provided of two community-based access programs: Healthy Children (9 model programs) and Healthy Tomorrows (20 award-winning programs). These programs are designed to address system barriers by forging model private-public partnerships that address local access problems. Finally, the report provides an overview of the public awareness component of the access campaign. This component will be designed to overcome the information barriers that many families face. (RH)

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AAP SPECIAL REPORT

SOLUTIONS

An overview of the Academy's three-part access to care campaign

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Facing barriers, finding solutions

WHAT ARE THE BARRIERS? WHAT ARE THE SOLUTIONS?

Millions of children face barriers when they try to obtain quality, comprehensive health care. Often, families face a combination of barriers that only compounds their problems. Statistics tell a sad story: Nearly 12 million U.S. children younger than 21 years old do not have health insurance. Countless others are "underinsured" or "uninsurable." One of every five children lives in poverty. One of every four pregnant women is not insured for maternity care. Fortunately, there are ways to overcome these barriers. There *are* solutions.

FINANCIAL BARRIERS

- Not having insurance
- Having insurance that lacks adequate benefits
- Having insurance that requires expensive cost sharing, making many benefits unaffordable
- Paying the cost of traveling to the physician
- State-to-state variations in Medicaid benefits

SYSTEM BARRIERS

- Health care systems (such as hospitals, clinics and health maintenance organizations) that are unable or unwilling to offer particular services or referrals
- Living in a rural or inner-city community where there are few or no services
- Having to deal with often confusing bureaucracies

INFORMATION BARRIERS

- Not knowing about the need for or value of early prenatal care or child health supervision services
- Not knowing how to access assistance programs, such as Medicaid, Medicare or handicapped children's programs

SOLUTIONS

- Legislative Efforts
- Community-based Efforts
- Public Awareness Efforts

Solutions

The AAP access to care campaign

About a year ago, the American Academy of Pediatrics published a special report titled, "Barriers To Care." In that report, we outlined the three basic barriers that millions of children and families face when they need quality health care: financial barriers, system barriers and information barriers. We also used the special report to tell the stories of several children and their families, and the obstacles that stand between them and health care.

Our aim was to give you a clearer understanding of why the Academy has named "access to care" as our top priority — and why the Academy has launched a long-term, three-part campaign to ensure access to quality health care for all U.S. children and pregnant women.

In this second special report, we'd like to better acquaint you with what the Academy is doing to provide access for our children. And once again, we will introduce you to some families — the St. Clairs, the Butlers, the Ottows, the Myers and others — who are doing their best to stay healthy.

The AAP access to care campaign has three components: federal legislative efforts to eliminate financial barriers; community-based efforts to address system barriers; and public awareness efforts to overcome information barriers. You'll notice that we've devoted much space in this report to describing financial barriers and our legislative efforts. Financial barriers are perhaps the most fundamental, widespread obstacles that families face.

1990 is the year that the access to care crisis has finally emerged in Washington, D.C. Due to tremendous pressure by business officials, labor leaders, the health and hospital care industry, consumer and professional groups, and ordinary citizens, Washington has begun to listen. Federal health agencies, members of the Bush Administration and many members of Congress are taking a fresh look at the problems of people who are uninsured, underinsured and uninsurable.

They are seeking new solutions.

Major changes in the American health care system are on the horizon. To ensure that legislative action benefits children, now is the time for pediatricians, parents and others to educate politicians and the general public about the critical needs of children who do not have access to comprehensive health care. The Academy has developed a legislative proposal to serve as a benchmark for health reform initiatives. In this special report, we outline the proposal and introduce you to some families our access campaign is designed to help.

The three-part AAP access to care campaign gives you a chance to be part of the solution.

We also outline our two community-based access programs, Healthy Children and Healthy Tomorrows. These programs are designed to address system barriers by forging model private-public partnerships in efforts that address local access problems. (We already have begun planning a third special report that will focus exclusively on community-based access efforts.)

Finally in this report, we provide an overview of the public awareness component of our access campaign. This component, which we've just begun developing, will seek to overcome the information barriers that many families face.

To say the least, the health care barriers that millions of children and families face are intimidating and the access campaign is a most ambitious undertaking for the Academy. The bad news in this realization is that inadequate access to quality health care is a major problem, a problem that takes a mighty toll in terms of dollars, suffering and our capability as a nation.

But the good news is that this is one problem that has solutions.

We've crafted our solutions within the framework of our access campaign. And, now, we ask you to join us. Work with us to ensure better health care for our children.

Be part of the solution.

—The American Academy of Pediatrics

Legislative efforts

Eliminating financial barriers

On the federal level, the Academy is undertaking major legislative efforts to eliminate financial barriers to care.

To ensure that children's needs are met, the Academy has crafted a legislative proposal to serve as a benchmark for health reform initiatives.

The AAP model would rebuild the foundation of the American health care system, starting with children and pregnant women. The Academy plan would expand the delivery of prenatal, preventive, acute, chronic and rehabilitative care and other health care services to all pregnant women and children without requiring new federal dollars.

Five key principles of the AAP plan are:

- Universal access to private health insurance will be provided for all children through age 21 years and pregnant women.
- Comprehensive health care will be assured by requiring a standard package of benefits for all those covered.
- Preventive services will be covered at no cost to beneficiaries.
- Fair payment for providers will help assure availability and quality of providers.
- Freedom of choice for patients and physicians will be retained.

The AAP access plan builds on and improves the nation's traditional employer-based health insurance system for covering employees and their dependents.

For those children and pregnant women who do not have employer-based insurance, the Academy plan guarantees that they will have private health insurance paid through a state administered fund. In part, that fund would be financed by the federal and state Medicaid dollars for children and pregnant women who currently receive Medicaid benefits. Additional funds would come from a tax on employers who choose not to provide coverage for children and pregnant women. (AAP consultants estimate that it would be about a 3.17 percent tax.)

Observers note that many aspects of the AAP access proposal are "politically attractive," including:

- Ensuring coverage of children and pregnant women first is logical and practical; it's a low-cost effort with long-range health benefits. In addition, ensuring coverage of children and pregnant women first could feasibly serve as a model and initial phase for universal access for all Americans.
- Expanding private health insurance to cover all children and pregnant women will cause little disruption to the current insurance system as possible.
- Folding Medicaid dollars into a system where private insurance is paid either by an employer or private insurance is paid by a state fund will eliminate the current two-tiered system of care.
- Eliminating the shifting of uncompensated care costs onto business and private sector insurers will more equitably spread the financial burden of covering the uninsured.
- Requiring no new spending from the federal government will respond to the problem of mounting budget deficits.
- Eliminating new Medicaid expansion mandates will allow state governments to better predict their expenditures.
- Requiring participation of all employers, regardless of size, will relieve some of the burden from the private sector through reduced cost shifting.

AAP officials suspect that achieving health care reform could be a long-term battle. Pediatrician coordinators in each AAP state chapter, known as Federal Access Legislative Coordinators (FALCs), have been briefed and are working to establish statewide networks of pediatricians to advocate for the AAP plan.

For additional information about AAP legislative efforts, contact: AAP Department of Government Liaison, 1331 Pennsylvania Ave. N.W., Suite 721, Washington, D.C. 20004-1703; (800) 336-5475.

The AAP legislative plan rebuilds American health care, starting with pregnant women and children first.

Kept from care

A nation waits as families face barrier after barrier

There must have been a time when people were shocked to learn that some children became sick or got sicker because they couldn't gain access to a physician.

Perhaps they learned about children in the Third World who died of preventable diseases and they decided to support charitable efforts to provide vaccines.

Lately, for some reason, when we learn that 33 million Americans, over one-third of them children, lack even basic health insurance coverage — that tens of millions have inadequate insurance that fails to cover basic physician services — that families grow so weary of fighting bureaucracies that they give up on Medicaid and other entitlement programs — we just don't take decisive action as a nation.

There are individuals who are upset, but complacent; they are just no longer shocked by the health statistics that point to declining child health. They dismiss these statistics as the cold evidence of the gaps in access to health care.

Other individuals and child advocacy organizations, including the Academy, claim that this country is waiting for a crisis — a nationwide outbreak of measles, a staggering number of low birthweight infants, an epidemic of teen pregnancy — before we act.

"I think that, as a nation, when we respond to crises — whether it's a hole on the ozone layer, national security, the savings and loans — we tend to wait," says former AAP president Donald Schiff, M.D. "When we look at what's happening to our nation's children, we're being tremendously short-sighted. We're missing the point. We have to act now to eliminate the barriers to health care if we are to have a healthy future."

In general, there are three types of barriers that families face: financial barriers (not having health insurance or having inadequate health insurance); health care system barriers (living in a rural or inner-city community where there are no or few health care services, having to travel great distances for treatment); and information barrriers (not knowing the value of preventive care, not knowing how to use available health care services.)

Dr. Schiff: We must act now if we are to have a healthy future.

The lack of appropriate insurance coverage is possibly the most critical gap in the U.S. health care system, notes Peter Boelens, M.D., a pediatrician in Vicksburg, Miss. The rural families he treats cannot begin to travel the sometimes 30 to 50 miles to see a physician nor begin to understand the importance of preventive care until they can pay for services.

"We try to empower people to take responsibility for their own health," Dr. Boelens says. "But the barriers are so insurmountable that we don't have time for the other obstacles like education, transportation and communication. You spend money and time and energy circumventing the financial problems and there's nothing left to help people with their personal access barriers. It's impossible to empower people to take on the responsbility of their own care — to learn when to contact a doctor or when to go to the hospital — because once they get there, they can't pay for it. Once you've done away with the financial problems, you'll find a way to deliver care."

Statistics support Dr. Boelen's claim. A 1986 national Health Interview Survey and a separate Robert Wood Johnson Foundation "Access Survey" show that uninsured families seek fewer health care services than their insured counterparts. The studies also show that uninsured Americans wait longer to seek medical care than those who have insurance.

Many Americans believe their employers provide insurance for children, only to learn that exlusionary

clauses prevent them from receiving reimbursement in the most desperate situations.

Children with birth defects or those with serious health conditions are often excluded from policies because they have "pre-existing conditions," notes Robert Biehl, M.D., the associate director of the Illinois Program for Children with Special Needs.

When an insured parent changes jobs, the new insurer may exclude a chronically ill child from insurance coverage, Dr. Biehl says. The expenses associated with birth defects and other chronic conditions often bankrupt families who can afford neither the special medical care their chonically ill children need nor the expensive coverage for their care.

Too often today, it's a family's pocketbook — and not their well-being — that determines the care they receive.

Some families with incomes less than 133 percent of the poverty line qualify for Medicaid insurance. Once they have the insurance, prenatal care and care for children as old as six years is most commonly covered. The problem is that many families find the system so complex or intimidating, that they sometimes give up before they complete their applications.

"There are so many people who might qualify for Medicaid and don't receive benefits," says Suzanne Hansen, Medicaid manager of the American Public Welfare Association. "Eligibility is so unwieldy that (a social worker or state employee is) not going to be able to explain it easily. It seems that the system is so complex, so short on money and staff, that it creates real problems for poor families who just want to get care. The fact is that it does appear that the system wants to exclude people. Chances are you'll never see a public service announcement on television announcing that, 'You too may be eligible for Medicaid.'"

Even when services are available, poor patients with and without Medicaid insurance must wade through the bureaucracy and wait for care, says Katherine Lobach, M.D., a member of the AAP Committee on Child Health Financing.

"There is a tremendous waiting time when you find a doctor who will accept your Medicaid card," Dr. Lobach explains. "First, you have to find a physician who will accept the low Medicaid reimbursement. If you go to many clinics, you must wait and suffer the discomfort of an unattractive atmosphere and impersonal attention."

Some groups suffer from lack of access to care more than others.

Dr. Jenkins: Teens also lack access to care. "Teens don't realize they need insurance until they get sick."

Many children do not receive adequate health care because their parents are unaware of the importance of preventive care, Dr. Boelens explains.

"At our clinic, we have community health workers who are trained to visit families," he says. "We're in a very rural area on the Mississippi Delta. There aren't any doctors around for miles. Added to that, many of our patients do not have phones, so we have a communication problem."

In addition, adolescents and young adults don't always understand why they need health insurance or put off physician visits until it is too late, says Renee Jenkins, M.D., a Washington, D.C. pediatrician specializing in adolescent medicine.

"Teens don't realize they need insurance until they get sick," Dr. Jenkins says. "We try to offer free programs, for those who are uninsured, but unless we make those programs especially attractive, they just won't go. There are some preventive medicine and family planning services available, but they don't like them because they are not treated well. They are not given value as patients. They're forced to do a lot of paperwork and they feel demeaned."

Think selfishly

This is the second AAP Special Report on barriers and access to health care. There have been numerous speeches given, reports published and committees formed nationwide to study access problems. The national news media have devoted much time to informing the American public about what happens when children and adults are prevented from getting the medical care they need.

We know the problem, but we still haven't acted, the Academy's Dr. Schiff says. Perhaps it's because we haven't thought "selfishly."

"Sure, you can say we're looking at this from a 'bleeding heart' point of view. We want all children to be healthy. These stories are sad," Dr. Schiff explains. "But, if you look at it from a strictly hard-nosed point of view, the fact is that we should act selfishly. We're talking about our work force 10 and 20 years from now. Illness is much more expensive than health."

— By Elizabeth Oplatka

Thinking twice

How families act when they do — and don't — have health insurance

What a difference insurance makes.

Here are two single working mothers with "good jobs." One parent, Victoria Engonopoulos of Chicago, has employer-provided health insurance for her 2-year-old daughter. The other parent, Alicia Loving-Cortes of New York, still has her "good job," but no insurance.

There are no tragedies here. Fortunately, neither of the children in this story has ever had anything but the usual medical bills. The events and attitudes in this story represent the subtle differences in the way people behave when they do and don't have insurance.

Loving-Cortes' son, Stephen Clyde, celebrated his third birthday on Feb. 23. He has never had health insurance.

Loving-Cortes, a freelance videotape editor, pays all of her medical bills out-of-pocket. Occasionally, she qualifies for and receives Medicaid coverage, but she has never used her Medicaid card.

"Most of my son's medical bills are $30 for a check-up, $35 for medication for ear infections, $40 for vaccinations," Loving-Cortes explains. "I can afford that. The Medicaid is for those times when something catastrophic happens and I'm unable to pay his bills. Every few weeks, I make more than the Medicaid limit, however, and I'm removed from the rolls. That's when I become concerned.

"I think the Medicaid system is awful," she continues. "If I wanted to stay on Medicaid, I'd have to stop working and go on welfare. Welfare wouldn't even pay my $600 New York rent. The system offers no incentives to return to work. I had to decide for myself that I wanted to work more. I believe that my son can sense my unhappiness when I am not working. I don't believe that is good for him either."

While she knows that she is unwise to wait, Loving-Cortes often makes sure that Stephen is "sick enough" to require attention, she says. She skimps on return visits and prescriptions when she believes that it's safe.

Children's health -- and happiness -- is too often determined by limits on income and inadequate employee benefits.

"My pediatrician is very patient," she adds. "She'll wait for payment for as long as it takes. But I'm very careful about doctor's visits."

A different story

Engonopoulos has employer-provided insurance for herself and 2-year-old Nora. As an administrator for a Chicago art museum, she pays a $40-a-month premium for Nora's coverage. There are no copayments or deductibles.

Engonopoulos is faithful to Nora's health supervision or "check-up" schedule. Nora has all of her immunizations and her pediatrician's clean bill of health.

"When she is sick, it's off to the doctor, right away," Engonopoulos says. "As a mother, when my baby is sick, I think, 'I have to take care of this right away. It can't wait.' I'm fortunate, because I don't think twice."

Engonopoulos says she never worries about financing Nora's health care because she knows that her employer will always provide a good benefit package. She does worry, however, that if she decides to change jobs, she won't be nearly as fortunate.

"I know that some day, I'll be in that position — some day I won't have insurance for her," Engonopoulos says. "I just know it. I won't stay in the same job forever. There will be a time to move on. I am an artist, a painter, and I know other artists who sell their work, who make good money, but who can't afford health insurance. That worries me."

It's impossible to live with hope for the future when a "better" job might mean loss of benefits and a gamble with Nora's health, Engonopoulos adds. For

now, she remains in her current position, which she says is still very satisfying, and considers herself "concerned, but happy with her security."

Loving-Cortes lacks that sense of security.

"I had the flu recently," she recalls. "I was out of work for a week. I had to go to the doctor. It was $230 just to walk in the door. It made me wonder whether I am doing the right thing. I'm trained as a video editor and I'm happy with what I do. I earn a decent living. But if something happened to my son, I don't know what I'd do."

Both parents would seek and receive equal care for their children if they both benefited from equal insurance, notes Katherine Lobach, M.D., a New York pediatrician. Dr. Lobach supports AAP access to care legislative efforts to provide health insurance to all U.S. children and pregnant women.

Such legislative efforts "would hopefully solve the most serious problem," Dr. Lobach says. "Working parents must rely on public services and charity because they do not qualify for Medicaid. These families are often in lower-paying service sector jobs. They are a major group with access problems."

In the end, guaranteed insurance would help keep parents like Engonopoulos and Loving-Cortes from ever having to make decisions to "make themselves poor" in order to go on welfare or Medicaid, or delay career decisions based on the benefits offered by employers.

Still, AAP officials acknowledge their concern that insured parents might not support a tax to insure their neighbors. While parents like Engonopoulos don't necessarily support this particular effort, they generally agree that "something" must be done.

"We have to do something so everyone can afford to go to the doctor," Egonopoulos says.

"It would be hard to pay a tax, directly or indirectly," she adds. "Every penny, every penny, is so precious. But somebody has to do something. Everyone from the homeless person to the person with a job and good benefits like mine needs insurance. I think about what it must be like to not be able to go to the doctor and it worries me."

— By Elizabeth Oplatka

Bittersweet charity

Families, physicians wonder how long 'free' health care can last

After 214 years, Americans still don't have the right to quality health care for their children. They have the right to charity.

Those whose incomes exceed Medicaid and public welfare eligibility limits find themselves exercising their right to ask for care as the health care system exercises its right to refuse it.

Parents like Mr. and Mrs. Joseph (they asked us not to report their full names) of Fort Collins, Colo., have an income that exceeds 133 percent of the federal poverty level. They will not qualify for Medicaid in 1990. Mr. Joseph is able to work only 20 hours because he injured his back. Mrs. Joseph is looking for a job. Their daughter does not qualify for Medicaid; at 9 years old, she's too old to be eligible.

"Whenever our 9-year-old catches a cold, she gets bronchitis," Mrs. Joseph says. "I could go to a doctor's office, but they could turn me away because I wouldn't be able to pay the bill and I don't qualify for Medicaid."

More than a year ago, Mrs. Joseph heard an announcement on a local radio station about the Healthy Start Children's Clinic, a mostly privately-funded center for low-income families. She now takes her daughter to the clinic.

Most patients there have incomes from 100 percent to 155 percent of the federal poverty line, explains Thomas Wera, M.D., the only full-time physician at the clinic. Most of Dr. Wera's patients are younger than four years old, but he does see patients as old as 18 years.

Every month, Dr. Wera and a number of volunteer pediatricians see from 375 to 450 patients. More than 25 percent of the patients he treats each month are new to the practice.

His program is funded by numerous sources: a Healthy Tomorrows grant from the U.S. Department of Maternal and Child Health; and local donations from the Rotary club, Gannett and the Colorado Trust, among others.

Locked out: It's impossible to count on health care charity.

"Most of our families fall into the insurance gap," Dr. Wera says. "They're too poor for insurance, too wealthy for Medicaid. Additionally, they have a difficult time finding a pediatrician to treat them. Regardless of whether they are using Medicaid or private insurance, physicians put a quota on the number of poor patients they can provide care to."

The local public health department clinics provide immunizations, but they lack other services, Dr. Wera notes.

"There is no follow up," he says. "Although they can get immunizations, there are no check ups. Certainly there is some triaging before children get their immunizations. They are checked for a fever or other indications that the child should not receive an immunization. But that's all."

The insurance gap touches others, as well.

A local hospital found itself delivering so many infants to mothers who had no prenatal care that officials decided to provide free prenatal care, Dr. Wera says.

"They realized that it's cheaper to provide free prenatal care and deliver healthy, full-term babies than it is to deliver pre-term infants to families who cannot afford their care," he explains. "Either way, the hospital figured it was paying for it."

Dr. Wera's patients are fortunate, he maintains. They have turned to charity and generous individuals who have picked up the bills that would be covered by insurance, if insurance was affordable.

But Dr. Wera says he wonders how long the charitable offers will be extended.

"Projects like that can't depend on that kind of generosity forever," he notes. "There's not a day I don't worry about where the money will come from next. A physician could not make a living here by accepting every patient who walks in his door. You just couldn't survive on what patients are able to pay."

With charity impossible to count on, there must be a better solution.

"It just can't go on this way," Dr. Wera says. "There must be some legislative solution. I just testified before a state senate committee on this subject. At least someone's proposing bills that would make it possible for children to have good health care."

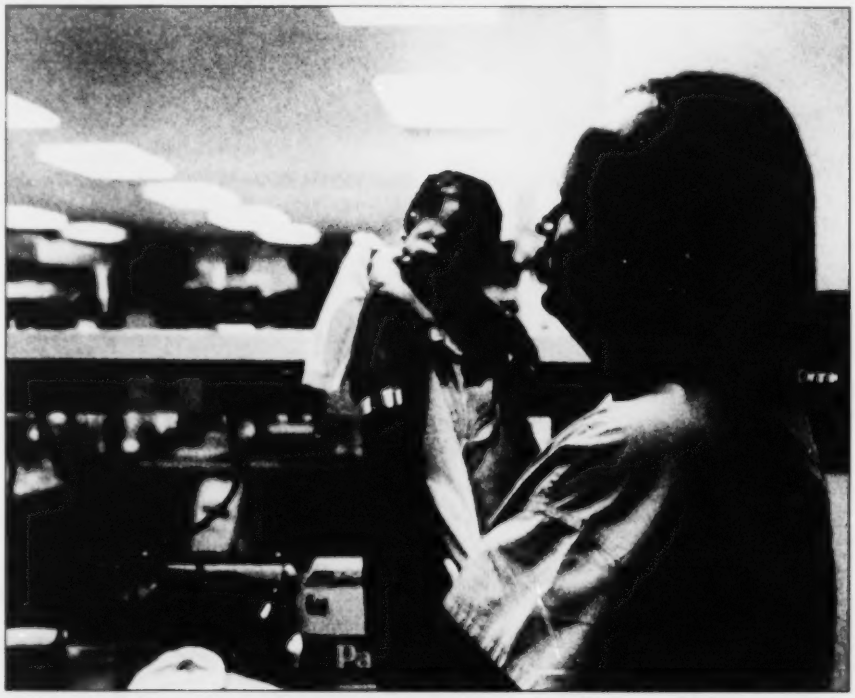
Legislation is being discussed at the national level, as well. Some plans, like the measures proposed by the Academy, would mandate comprehensive health insurance for all children, adolescents and pregnant women. Under the the AAP plan, families would no longer have to depend on their right to ask for charity; they would have a right to affordable insurance.

Meanwhile, Mrs. Joseph — and so many others — are left wondering.

While she has found a "free" pediatrician for her 9-year-old, there are other health problems best handled by specialists. Who, she wonders, will volunteer those health services?

"My child was getting headaches," Mrs. Joseph recalls. "We waited a while because I figured it was just a sinus infection. Finally, we went to see Dr. Wera who sent us to an optometrist. I didn't have a way to pay the optometrist. Thank God for the Lion's Club. They helped me pay for the optometrist. The optometrist said my daughter needed glasses. Now, who is going to pay for the glasses?"

— By Elizabeth Oplatka



Dr. Kurlinski: Added complexities of being "underinsured."

On their own

Some insurance leaves families unprotected

Echo Myers and her husband Amos have employer-provided health insurance.

But several months ago, when their son was born with a life-threatening condition, their "insurance" nearly threw them into bankruptcy.

"I had to have an emergency C-section," Mrs. Myers, of Las Vegas, explains. "Our baby, Robert, was born with gastroschisis — part of his intestine was outside of his stomach. That's when we learned that our insurance wouldn't cover us."

Since the Myers had been married less than a year, the insurance provided by Mr. Myers' employer only covered $10,000 of Robert's $250,000 hospital stay.

There is a terrible, ironic twist in the Myers' story. According to his insurance policy, on Robert's first birthday, he will be eligible for $250,000 in health insurance coverage — the same $250,000 he lacked when he was born.

The policy covered none of Mrs. Myers' expenses, including the delivery and a six-day hospital stay. Nor will

The Myers: "How are we supposed to get out of this?"

their policy cover any of Robert's medical care before his first birthday.

"We just haven't paid for it," Mrs. Myers admits. "We've thought of declaring bankruptcy, but we felt that wasn't fair. Right now, we're trying to pay for what we can as we can. If we declare bankruptcy, nobody gets anything."

The Myers — like millions of other U.S. families — believed they were covered. They believed that as part of his benefits, Mr. Myers' employer, a Las Vegas casino, had purchased all of the health insurance his family needed.

"Our baby needed surgery and time in an intensive care nursery," Mrs. Myers recalls. "We believed he was entitled to that. I needed a C-section and a long recovery afterward. I thought I was entitled to that."

Exclusionary clauses in health insurance policies help employers keep insurance coverage affordable, notes Hazel Witte of the U.S. Small Business Administration. But high costs have eroded dependent coverage, especially for children.

"So many families fall through the cracks between employer-provided, self-purchased and Medicaid insurance," adds former AAP president Donald Schiff, M.D. "We see the evidence of what lack of comprehensive insurance does to children's health care. Insurance plans aren't designed to cover children's needs."

The Myers are not counted among the 33 million uninsured Americans we discuss, points out J. Parker Kurlinski, M.D., a neonatologist and vice president of the AAP Nevada Chapter. Families like the Myers are "underinsured," but as long as they have some insurance, they are considered "covered."

"Many of these moms are ineligible for state funds or Medicaid," Dr. Kurlinski says. "These families are considered 'land rich' but 'cash poor.' They have good-paying jobs, but sometimes their insurance doesn't kick in when they need it."

The Myers currently receive a special, expensive infant formula through the federal Women, Infants and Children supplemental feeding program. The state Office on Crippled Children Services has paid a small percentage of their bills.

The Myers tried to apply for Supplemental Security Income, a federal program that provides cash to families with seriously ill children, but an official told them Robert wasn't sick enough to receive aid.

"At least they didn't tell me that I wasn't poor enough," Mrs. Myers says. "They didn't even let me apply even though he will probably require another surgery and periodic check ups during his first year."

The family also applied for Medicaid. There they were told they weren't poor enough to receive assistance.

"My husband works full time, so we didn't qualify," Mrs. Myers says. "So I applied for welfare. We didn't get that either. Now, how are we supposed to pay these bills? How are we supposed to get out of this?"

"Something to hold onto"

Activities like the AAP access to care legislative efforts give families like the Myers "something to hold onto for the future," Mrs. Myers says.

"It isn't here right now, but it makes me feel better to think that someone realizes there is a problem and is trying to fix it," she says.

Under the AAP model proposal, pregnant women and children would be guaranteed a basic benefits package through employer provided health insurance or insurance paid through a state fund. Prenatal and children's preventive care would be covered with no copayments or deductibles. Most important to families like the Myers, the insurance would cover "catastrophic" care as well. Copayments and deductibles for illnesses and other medical exenses would be figured on a sliding scale according to family income. Coverage wouldn't be restricted, but the amount a family would pay in any given year would be limited. Pregnant women would be covered until 60 days after delivery.

Mrs. Myers, who says she is proud of having worked full-time until her son was born, wants to pay her son's medical bills. She says she's concerned that the day will come when her son will be turned away because the family has so many unpaid bills.

"I got the sense at the hospital that if you don't have insurance to cover you, you're not treated as well," she states. "I could be wrong. The medical treatment we got was great, but ... nobody explains why we can't qualify for those things.

"I remember that before he was born, I found out that they take pictures of newborns for their families," she says. "I asked them to take his picture after his operation, but they didn't listen to me. He was in the hospital for weeks, and they never took his picture. My husband went on the graveyard shift to make more money. So we're never together as a family. We've never had a picture taken. That might not sound like much, but I keep thinking that insured families have their pictures taken."

By Elizabeth Oplatka

The 'uninsurable' child

It's probably one of the most difficult things for a businessman to do, but John Ottow, a self-employed landscaper in Chatham, Mass., has started turning customers away.

He hates to do it, but Ottow — a husband, homeowner and father of four growing children — has little choice in the matter. If his monthly income increases by just $20, he risks losing eligibility for a federal program that helps pay the medical bills for his chronically-ill daughter.

The Ottows can't earn more than $26,000 a year, or they will lose the $250 a month they receive in federal assistance to help pay the phenomenal medical expenses for Jenna, their 6-year-old daughter who was born with a cranio-facial birth defect that requires frequent surgeries, therapy and the attention of a team of medical specialists.

"It's a real catch-22 for us. We are at the edge of eligibility, and just $20 more a month would put us over," says Jill Ottow. "For a family of six, $26,000 is not a whole lot of money. It's unfair to have to limit our income, it's ridiculous. I also would like the personal freedom to start a career of my own if I want, but I can't under SSI (Supplemental Security Income)."

The Ottows are hoping to get involved in a Massachusetts program that provides health insurance on a sliding income scale, which would allow them to increase their earnings without the fear of losing coverage. If that works out, their days with SSI would be over, allowing John to stop turning customers away and giving Jill the chance to start her own career. She wants to start an advocacy-training program for parents with children who have special needs.

"We think we can increase our income by $10,000 to $12,000 once we get into this program," Mrs. Ottow says. "But it's kind of scary, because every day we hear something about the legislature wanting to cut it. Yes, I guess dropping SSI right now is a big gamble, but so is trying to raise a family on $26,000 a year."

The Ottow children: Three are insured; young Jenna is not.

The Ottows resent how the SSI program limits their financial freedom, yet aside from the Massachusetts program, they don't have much choice. Jenna Ottow was born with Apert's disease, a cranio-facial birth defect that is accompanied by hand and foot malformations and a partial hearing loss. It is one of several conditions most insurance companies categorize as "pre-existing," which means that little or none of the medical expenses related to the condition are eligible for coverage.

So even if John Ottow were to work under an employer, it is unlikely that the company's insurance policy would cover any of Jenna's medical expenses. Being self-employed, John Ottow instead pays $400 a month for Blue Cross/Blue Shield health insurance for himself, his wife, Jenna, and his three other children. The policy requires a 20 percent co-payment for each medical claim.

Since birth, Jenna has undergone 15 different surgical procedures, including shunt implants in her skull to drain fluids and four operations on her hands and feet. She is soon to have her entire face rebuilt, a necessary procedure Mrs. Ottow estimates will cost up to $50,000 in hospital and surgeon's fees and various other costs.

Mrs. Ottow says SSI and the private insurance don't do much to ease the family's financial strain.

"We pay the $400 a month, and then we have to come up with 20 percent of the cost," she explains. "Well, for most of Jenna's expenses, 20 percent is a tremendous amount. That's money we can't afford to pay."

A 20 percent co-payment for Jenna's facial restructuring operation could cost the Ottows up to $10,000 or more. That's in addition to Jenna's other expenses that are not covered by insurance, including: the travel costs of driving her 100 miles twice a month to Boston Children's Hospital; the costs of having to purchase specially-fitted shoes and clothing; and the costs of child care for the other Ottow children while Mrs. Ottow is with Jenna at various therapy sessions or medical visits.

The Ottows' financial situation is common among families with chronically-ill or disabled children, but it by far is not the worst case scenario. Like most of these families, insurance coverage for Jenna's condition is minimal and her medical expenses are draining the family coffers, but there is one factor that makes the Ottows somewhat more fortunate than other families in similar situations — they can afford to insure their other three children.

Some families cannot say the same.

Teresa and Julian Rodriguez, of Fort Collins, Colo., have a 21-month-old son, Robert, who has cytomegalovirus, a chronic condition that causes mental and motor retardation and other medical complications. They also have two other children, Krystle and Alyssa.

As a painter working under a self-employed businessman, Julian Rodriguez earns $16,800 a year and receives no health benefits. His earnings are just enough to pay for car insurance, car payments, food, clothing and medi-

Robert, an uninsurable child: One of many thousands.

cal care for his children and rent for the trailor home in which they live.

"We are making it, but it's very close," says Teresa Rodriguez. "We never have enough for any luxury, but right now we are not concerned with luxuries. The car is an absolute necessity. We drive about 150 miles a month for Robert's therapy and doctors."

Robert qualified for Medicaid about six months ago. Much of his medical expenses, which include therapy, orthopedic services and equipment, medications and various medical specialists, are covered by either Medicaid or by a state program for handicapped children.

But with their current annual income, the Rodriguez's cannot afford health insurance for their two other children. For colds, sore throats or routine checkups, Mrs. Rodriguez takes the two girls to Thomas Wera, M.D., F.A.A.P., at the Healthy Start Children's Clinic. Dr. Wera, one of few Medicaid providers in the area, allows the Rodriguez family to pay whatever they can afford for each visit.

So far, Krystle and Alyssa Rodriguez have not suffered any serious illnesses or accidents — a situation Mrs. Rodriguez doesn't like to think about.

"We pay $490 every six months for car insurance, so if anything happened to them in the car, it would be covered," she explains. "But I don't know what would happen if they got hurt outside or something. If I had to sell all my stuff to pay for it I would do it. These are my children and I will do what I have to to take care of them."

The Rodriguez's could increase their earnings to afford insurance for Krystle and Alyssa, but they would then risk losing eligibility for Medicaid and the state program that helps pay for Robert's huge medical expenses. They would then be left with no insurance for Robert, since most private insurance companies exclude his condition from coverage.

Classifying it as a "pre-existing condition," Julian Rodriguez's previous employers refused to cover Robert under their policy. That policy wouldn't have been much help anyway, Mrs. Rodriguez adds, because it required a $300 deductible and a $100 co-payment for each claim.

While some of their circumstances differ, the Rodriguezs and the Ottows share one thing in common — an uninsurable child. And there are thousands more in the same situation.

"Many parents think this is only happening to them, that they are just mismanaging their family, but this is a huge national problem," notes Betsy Anderson, of the Association for Children with Special Needs. "There are so many different situations. Sometimes the child is completely uninsurable, but more often the policies don't fully cover all the services and needs that these children require.

"I had to struggle just to get my son a special cushion for his wheelchair," adds Anderson, whose son has Spina Bifida.

She points out that some of the more common non-covered expenses include speech therapies, respite care, or day care for children with special needs and adaptive equipment.

"Because some of these things are uninsured, a lot of these kids end up being more dependent than they need to be because their environment is lacking," Anderson says. "They can't reach their full potential."

AAP legislative efforts address many of the problems encountered by families who have children with special needs.

One basic principle promulgated by the Academy is that all insurance must cover pre-existing conditions. In addition, the Academy argues that employers must offer a "coordinated care benefit package" that would cover many of the services currently not covered under most private or employer-based policies. The Academy also maintains that certain hospital and physician services — including all inpatient care for acute and chronic conditions; acute home health care on a short-term basis; inpatient and outpatient physician care for acute and chronic conditions; and subspecialty consultations and treatment — should be covered, as well.

Jill Ottow says she hopes that public policy-makers will consider some of the more unusual expenses of special needs children when shaping a solution to the health insurance problem.

"Every time I drive 100 miles to take Jenna to the hospital for therapy, it costs money," she says. "It's not just gas, but I have to pay for meals, for parking, for child care for my other children — it all adds up. There are just so many costs involved that I can't even begin to make a list. They are costs that most legislators and bureaucrats don't think about when they're back there, making policies that directly affect our lives."

— By Debra Fleischman

Broken Stereotype

The majority of uninsured American children live in two-parent, white families where there is at least one full-time employed parent earning an income above the poverty line. In 1986, about 87 percent of uninsured children lived in families with at least one working parent. More than half of uninsured children lived in families with full-time, year-round workers.

Medicaid muddle

"What good is having a Medicaid card if nobody wants to take it?"

It was seven months into her fourth pregnancy, and 22-year-old Debbie St. Clair was in desperate search of a physician who would give her a prenatal checkup.

But for reasons she still doesn't understand, Debbie couldn't find a physician in Ft Collins, Colo., who would accept her Medicaid card. After literally thumbing through names in the phone book and getting turned down by each physician she called, Debbie ended up going to the hospital emergency room, begging hospital staff for a simple prenatal examination.

She realized it wasn't a medical emergency, but going to the hospital was the only way Debbie could find to see a physician and learn if the baby inside her was safe and healthy. Her son, Paul, had died one month after delivery about four years before, and Debbie didn't want to risk a recurrence.

"They looked at me like, 'why are you here?'" Debbie recalls. "I told them the truth, and they took care of me. I was really surprised. I thought for sure they wouldn't take me because I wasn't an emergency."

A few weeks later, Debbie contacted the state Medicaid Department, who put her in touch with a clinic that provides prenatal care to pregnant women on Medicaid. However, she says she felt like she was getting "second-rate care," especially when it came to the delivery-room physician.

"It was his first delivery," she says. "I felt like a guinea pig laying there. The (umbilical) cord wrapped around my baby's neck, and this guy wasn't sure what to do. I told the nurses I didn't want him delivering my baby, but they said I had no choice because I was going through the woman's clinic and I was on Medicaid, and this was the only doctor who could do it."

Shortly after that experience, Debbie was put in touch with the Healthy Start Children's Clinic in Ft. Collins, Colo.

Reaching out: Says one mother, "I don't like being on Medicaid, and if I didn't have to, I wouldn't."

Through the clinic, the St. Clairs now have a pediatrician, Thomas Wera, M.D., FAAP, who is one of six pediatricians, 75 community physician volunteers and 20 family physicians who donate their Medicaid reimbursements to the clinic. In exchange for those funds, clinic staff completes all of their Medicaid paperwork.

Debbie said it was a great relief to finally find quality medical care for herself and her three children.

But she still doesn't understand why it had to be so difficult.

"Finding a doctor is so hard. I don't understand why they won't take Medicaid," she says. "Is it because Medicaid doesn't pay as much as other people do, or what? I still don't get it. I don't understand why it has to be so hard."

Debbie's experience illustrates a major gap in the Medicaid system. While expanded eligibility is allowing more families like the St. Clairs to receive Medicaid coverage, the number of physicians participating in the program is decreasing, leaving many of these families right back where they started — in search of medical care. As Debbie St. Clair puts it: "What good is having a Medicaid card if nobody wants to take it?"

Medicaid directors across the nation are asking themselves the same question. Since April 1990, all states have been required to offer Medicaid coverage to pregnant women and children up to 6 years with family incomes below 133 percent of the federal poverty level (FPL) regardless of family structure. For a family of three that would be $13,413. Additional options currently allow states

to cover infants and pregnant women up to 185 percent of the poverty line, but dwindling physician participation is discouraging many states from taking advantage of the option.

"Our biggest barrier is lack of pediatrician participation," notes J. Clinton Smith, M.D., FAAP, who at the time of this interview served as the Medicaid director in Mississippi, a state where 18 percent of the population receives Medicaid benefits.

"Because of the low participation rate, these people are going to the emergency rooms late at night or to the federal clinics," Dr. Smith says.

"Don't get me wrong, there's nothing wrong with the federal clinics, but our feeling is that the private pediatricians offer the best care possible, and we want Medicaid patients to get the same care as everybody else. That simply is not the case; at least in Mississippi it isn't."

Research shows that Mississippi is not alone in its shortage of Medicaid physicians. A 1989 national survey of AAP members published in the April 1990 *Pediatrics* found that between 1978 and 1989 basic participation (treating any Medicaid beneficiaries) declined to 77 percent from 85 percent. The amount of AAP members with limited participation (seeing only some Medicaid recipients who request care) increased from 26 percent to 39.4 percent during the same period.

Physicians offer a variety of reasons for not accepting any Medicaid clients or for limiting their participation in the Medicaid program, including:

- *Low reimbursement rates.* The 1989 AAP survey showed that the average reimbursement for a Medicaid well-child visit is 53 percent of the usual fee that pediatricians receive for private-pay patients.
- *Complex regulations, payment delays, paperwork.* The survey also showed that 24.6 percent of the AAP members' Medicaid claims are returned for additional work, that it takes an average of 7.8 weeks for Medicaid to make a payment and that it takes an average of 8 minutes to fill out a Medicaid claim. These have all worsened during the past decade.
- *Lack of patient compliance.* Many pediatricians say Medicaid patients don't carry out their instructions and are more likely to break appointments than their private-pay patients.
- *Frequent rejection of claims without explanation.*

A Medicaid card tells a physician that the patient doesn't have access to private health insurance because of a lack of employment or a lack of employee-dependent coverage. Medicaid recipients, like Debbie St. Clair, are therefore often

The bottom line

The uneasy relationship between children and business

"It used to be when you got sick, people would tell you, 'Don't worry about the money, worry about getting well.' Today, nobody will tell you, 'Don't worry about the money.'"

— Peter Thexton , Health Insurance Association of America

For most of the past 50 years, money was not the key determinant in gaining access to health care. American workers relied on their employer as the means of obtaining affordable health care for themselves and their dependents.

However, the last decade has seen a change in this practice.

Today, money — or lack of it — is the major reason there are 33 million uninsured Americans.

Some health care premiums have become so expensive that companies have stopped offering them; or if they do, costs are passed along to employees, particularly for employee's dependent's coverage.

Consequently, many employees cannot afford to purchase the coverage.

While the ultimate decision is often placed in the hands of the employee, chances are good that the results of such a choice will reach far beyond any one person. Encompassed in that decision is the fate of some 12 million uninsured children.

During the 1980s, the already unstatisfactory relationship between children and employer-based health insurance grew worse. In the first half of the decade alone, the population of uninsured children grew nearly 14 percent. For lower income children (whose numbers increased by nearly one-third over the same time period) the relationship has all but disappeared.

Contrary to the popular stereotype, the majority of uninsured children comes from families in which at least one parent is employed. In fact, two-thirds of all uninsured people have a connection to the workforce, either as an employee or as a dependent of an employee, according to a congressional special report titled, "Finding the Best Prescription for the Nation's Health-Care Woes."

That connection is most tenuous among workers in small businesses.

Only half of all insured workers in small businesses have dependent health insurance coverage, compared to 61.7 percent in larger companies, according to a survey report prepared for the National Association for the Self-Employed (NASE).

Small business owners offer several reasons for not providing better coverage — insufficient profits, lack of employee interest — but they most often point to the high cost of premiums and they say employees are sometimes covered elsewhere. Premiums for small businesses are about 10 to 15 percent higher than premiums for large firms because small businesses have fewer people among whom to spread insurance risk, but they must still pay the administrative costs of making insurance available.

The NASE survey also asked small firms what would entice them to offer health insurance. Most replied that they would require a good price and benefit package, or the addition of more employees to their work force. When

Dr. Harvey: Citing business benefits and moral grounds.

asked what effect mandated health insurance would have, 61 percent responded that it would hurt their business while 25 percent responded that it would have no impact.

Bound together

Health insurance is not without its costs, but both children and business benefit from a healthy relationship.

Children and business are "inextricably bound," notes a report issued by the Southern Governors Association titled, "Boardrooms and Babies: The Critical Connection." The report suggests that boardroom policies can influence the health of a newborn while that baby's health will ultimately have an impact upon the profits and productivity of corporate America.

Productivity is the key to the relationship. Having healthier children means that an employee is absent less often due to the illness of a child. In turn, more days on the job yields greater productivity. Moreover, a commitment from a business to "invest" in its workers is more likely to evoke a greater commitment from workers. In turn, a greater sense of satisfaction and security can be a positive influence on productivity.

Observers cite other long-term benefits, as well. Businesses can use their benefit packages, specifically health care insurance, to attract the most desirable candidates for jobs. And businesses that currently provide insurance would ultimately save money if everyone were insured because cost-shifting practices would be eliminated. Cost shifting occurs as hospitals and doctors shift the expense of uncompensated care to those who pay for care. Ultimately, many insured employers and employees pay for this through higher insurance premiums.

One cost associated with not providing health insurance is a "moral" cost. "Children don't choose which families they are born into," former AAP President Birt Harvey, M.D., is fond of saying. "They don't determine how much income their parents will earn. We must provide health insurance for children on moral grounds, as well."

Despite moral correctness and long-term benefits, AAP officials acknowledge that convincing business about the value of health insurance for children and pregnant women will not happen overnight.

The majority of pediatricians run small businesses themselves — and they may face the worst dilemma when it comes to balancing the bottom line with what's best for children.

— By Mike Lynch

unable to gain access to mainstream medical care.

The Academy is working to erase this barrier.

The Academy contends that all U.S. children through age 21 years and pregnant women should have access to comprehensive health insurance, either through an employer or private insurance paid through a state fund. The state fund is not "just another Medicaid." The fund would cover children and pregnant women left uncovered by employers — employers, that is, who decide to pay a payroll tax rather than provide insurance.

Under such a change, physicians wouldn't know which source — an employer or the state fund — the insurance would come from. In turn, current stigmas would be erased.

It would also help ensure that comprehensive care is equally available to each and every child.

"I feel like the really good doctors don't take Medicaid, and sometimes we aren't treated real well by the ones we have gone to see," Debbie says. "It's like, 'get us in and get us out' as fast as they can."

In addition, guaranteed access to health insurance would erase the difficulties that are currently involved with complicated Medicaid eligibility requirements, which vary from state to state. For example, in some states, families can earn up to 80 percent of the poverty level and qualify for Medicaid, while in other states eligibility is limited to those with incomes under 25 percent of the poverty level.

Debbie St. Clair also has experienced eligibility barriers. For several months, when she was married and employed at a fast-food restaurant, she couldn't qualify for Medicaid.

"I didn't really understand it. They said because I was married and not a single mom I couldn't qualify," she recalls. "Then when I was working at Jack-In-The-Box, I had to get insurance through some other program for people who had income other than welfare."

The Academy is calling for all U.S. children and pregnant women to be eligible for health insurance, regardless of income, marital status or number of children in the family. Under such a plan, people like Debbie St. Clair, an unfortunate victim of a system that too often doesn't work, wouldn't have to worry about not getting the health care they need.

"I don't like being on Medicaid, and if I didn't have to, I wouldn't," Debbie says. "It can be very degrading. You get dirty looks from people ... but I just look right back at them like, 'Hey, you got to make it somehow, you know?'"

By Debra Fleischman

Community-based efforts

Addressing system barriers

...ve of AAP community-based efforts is to support the development of programs that use innovative approaches and models to deliver needed health care to underserved children. To that end, the Academy is coordinating two separate community-based programs: Healthy Children and Healthy Tomorrows.

Healthy Children is a nationwide effort designed to help communities identify and meet their local health care needs. Instead of awarding grants, Healthy Children supplies information and consultation based upon the experiences of other communities across the nation that already have developed specific health care programs for children. The Academy is coordinating the Healthy Children program through a grant from the Robert Wood Johnson Foundation.

Under the program, pediatricians in each AAP chapter have been trained to help motivate and assist others within their chapter to provide effective leadership in initiating child health care programs. Healthy Children founder Philip Porter, M.D., FAAP, serves as a consultant, developing related publications, making presentations at various meetings and conducting site visits where pediatricians are initiating new programs.

Healthy Tomorrows is a program of the federal Office of Maternal and Child Health, developed in collaboration with the Academy. Healthy Tomorrows awards five-year grants for pediatric, community-based projects. The first Healthy Tomorrows grants — totaling $500,000 — were awarded to 10 community-based projects in 1989. Another 10 grants were awarded in the fall of 1990.

The grants are designed to build public-private partnerships by guaranteeing that federal funds represent no more than one-third of a project's annual operating budget. The additional funding must be secured from individuals, corporations, foundations, state and local resources, or other non-federal agencies.

Healthy Tomorrows grants are awarded to programs that focus on preventive strategies in addition to improving access to care.

For additional information about AAP community-based efforts, contact: AAP Division of Community Health Services, P.O. Box 927, 141 Northwest Point Blvd., Elk Grove Village, IL 60009-0927; (800) 433-9016.

The AAP community-based efforts — Healthy Children and Healthy Tomorrows — foster model programs that meet the needs of underserved children.

Family Care Center Health Project: Trying to fill "the gap."

Success story

A Kentucky program builds a brighter future

Seventeen-year-old Erica Butler no longer worries about not being able to finish her high school education or start a career, thanks to a new project in Lexington, Kentucky, that helps build brighter futures for teen mothers and their young children.

Through the Family Care Center Health Project, Erica receives low-cost day care for her 15-month-old daughter four days a week while she attends free General Education Diploma (GED) classes, vocational guidance, life management and peer support sessions — all at the same location.

"If the center wasn't here, I wouldn't know how I could do it on my income," says Erica, who left high school as a sophomore after she became pregnant with Jalleesa. "You need these classes. You can't just go down and expect to pass the GED without taking anything to prepare you."

The Family Care Center, which has been operating since October 1989, provides parent education, vocational guidance, day care service and peer support groups for low-income parents aged 17 to 21 years and their children, up to age 6 years. The bulk of the center's clients have been single, teen mothers who survive on Aid to Families with Dependent Children (AFDC) and Medicaid, notes Melissa Hopkins-Dunbar, the center's health services director.

But with the help of a Healthy Tomorrows grant — provided through a joint effort of the Academy and the U.S. Bureau of Maternal and Child Health — the center plans to add a variety of health and psychological services to its program and extend those services to 100 families whose incomes are too high for Medicaid, but at or below 185 percent of the federal poverty level.

"Eligibility for welfare is so low in Kentucky that many of these at-risk families are not eligible for Medicaid and can't afford private health insurance," Hopkins-Dunbar says. "We are trying to fill that gap."

In Kentucky, AFDC eligibility is set at 28.9 percent of the federal poverty level. For Medicaid eligibility, a family of three can make no more than $308 per month, with the threshold slightly increasing if the family also receives AFDC.

Erica lives with her mother and also works nights as a department store cashier and sales clerk, which makes her ineligible for both AFDC and Medicaid.

The center helps remove several barriers to care that low-income parents face in the Lexington-Fayette Urban County area, Hopkins-Dunbar says.

"A lot of the barriers are financial. But a lot of the people we serve are teens, so transportation also is a big problem," she explains. "There are a lot of

services offered throughout the area, but it's the 'piecemeal approach' — one is here and one is over there. The center sort of puts it all in one place."

Once the health service portion of the Family Care Center Project gets going, Erica won't have to borrow her mother's car to drive Jaleesa to see her pediatrician, because he is one of a few pediatricians who will operate out of the center a few days a week.

At full operation, the center will have 16 day care units for 200 children; classrooms for parent education and job training; a health unit with pediatrics, pediatric dentistry, nursing, psychological services, and occupational, physical and speech therapies.

Some health professionals are being provided by the University of Kentucky Department of Pediatrics and Pediatric Dentistry Program. They will be paid for their services through Healthy Tomorrows grant funding and also through the university.

In addition to GED training and vocational guidance provided by a job specialist, parents also go through a Life Management course that teaches them how to balance a checkbook and other basic skills to help them better function in society, Hopkins-Dunbar notes.

About 80 percent of the center's clients will be Medicaid recipients, with the remaining 20 percent being families whose incomes make them ineligible for Medicaid. Hopkins-Dunbar says every family, regardless if they are receiving services through the Healthy Tomorrows grants or through Medicaid, will receive the same quality and amount of services.

"The only difference will be their source of funding," she says.

All children and parents accepted into the project also are eligible to participate in an infant stimulation and preschool enrichment program that aims to provide positive interaction between parents and their children, Hopkins-Dunbar says.

"It brings the parents together with their children. That and the peer support are important parts of the program," she says. "Many of these teens are living alone in an apartment with just their one or two children. They need the support of their peers."

The Family Care Center Health Project is one of 20 community projects to receive Healthy Tomorrows grants. Each project, which in some way aims to improve access to health care in the community, will receive $50,000 each year for the next five years. They will be eligible for federal funds so long as the Healthy Tomorrows dollars constitute no more than one-third of their total budgets after the first year.

— By Debra Fleischman

Scenes from the center: Some services are offered elsewhere, but, notes one official, "The center sort of puts it all in one place."

Healthy Tomorrows

An overview of 10 programs awarded grants in 1989

Project for Attention-Related Disorders. *(San Diego Unified School District, Health Services Department, San Diego, Calif.)*

The San Diego Unified School District program is developing a network that provides diagnostic and therapeutic intervention services to low-income children who exhibit symptoms of attention deficit disorder.

Healthy Start Children's Clinic. *(Healthy Start Children's Clinic, Fort Colllins, Colo.)*

With the help of 75 physicians volunteering their services, this program provides access to high-quality, comprehensive pediatric care for area children from indigent families.

Parent-Pediatric Partnership. *(Hawaii Department of Health, Family Health Services Division, Zero-to-Three Hawaii Project, Honolulu)*

The aim of this program is to develop a model for providing comprehensive, coordinated, family-centered, multidisciplinary care for environmentally at-risk infants and toddlers in low-income, culturally diverse settings.

Resources, Education and Care in the Home (REACH). *(Futures, University of Illinois at Chicago, Maternal/Child Health Nursing, Chicago)*

UIC is developing a team of trained community members who, under the supervision of nurses from the school's Maternal-Child Health Nursing program, conduct home visits to promote primary health care for low-income inner-city Chicagoans.

Family Care Center Health Project. *(Lexington-Fayette Urban County Government, Department of Social Services, Lexington, Kentucky)*

This program provides comprehensive care for children living in families with incomes too high for Medicaid benefits, but at or below 185 percent of the federal poverty line. All families

accepted can participate in day care and preschool programs. Parents have the opportunity to complete their high school educations and participate in vocational training.

Sharkey-Issaquena Health Alliance. *(The Luke Society, Cary Christian Health Center, Vicksburg, Miss.)*

This grant increases the services offered by the Cary Christian Health Center of Vicksburg. Added to the list of services were a perinatal care network, and prenatal and parenting classes. In addition, the center placed a nurse in a high school, hired a social worker specializing in child abuse and developed a training program for lay people interested in serving as home visitors.

Preventive Primary Care Services for Children in Substance Abusing Families. *(The Children's Hospital of Buffalo, Buffalo, New York)*

This program adds services to an existing program that provides primary care to children at high risk for physical or sexual abuse due to parental substance abuse. The added dimension involves families receiving parent education classes and intensive, home-based support from "resource mothers" who are recruited from the community and trained to provide parenting tips.

Community-Based Medical/Educational Program. *(Ken-Crest Centers, Plymouth Meeting, Penn.)*

This program adds pediatric and nursing care to an existing early intervention program for medically fragile and technology-dependent children. This care involves developing an individual medical program for children and educational support programs for parents.

Primary Care Physicians: Caring for Low-Income Children with Special Health Needs.

This program aims to provide family-centered, community-based, coordinated care for chronically ill children from low-income families. Primary care physicians provide a medical home for these children as well as a care coordinator.

A Family-Focused Strategy for Reducing Premature and Unprotected Sexual Activity Among Minority Youth in School-based Clinics. *(Dallas County Hospital District, Children and Youth Project, Dallas)*

Aimed at a group of 400 minority 10-year-olds, this program stresses education to reduce the incidence of premature and unprotected sexual intercourse. As part of the program, all receive annual health maintenance evaluations and half receive family counseling and intervention services. Peer support groups are developed as the program progresses.

Healthy Tomorrows

An overview of 10 programs awarded grants in 1990

Primary Care for Children in Foster Care and Homeless Shelters. *(Family Intervention Center, Children's Hospital of Pittsburgh)*

The goal of this project is to coordinate the primary health care delivery and monitoring of 500 children who live in homeless shelters or are in foster care. Services include developing individualized health care plans for each child, linking them with permanent "medical homes" and providing or monitoring necessary follow-up care.

Healthy Tomorrows for New Haven. *(City of New Haven, Department of Health, New Haven, Conn.)*

In an effort to strengthen existing school health resources, an elementary school and a middle school will serve as access points for children to obtain comprehensive health care. The elementary school site also will provide services to newborns and preschoolers in the area, which is geographically isolated and includes three public housing projects.

Jackson County Prenatal Clinic. *(Region II Community Action Agency, Jackson, Mich.)*

A recent needs assessment found the perinatal population to have the most severe health needs, with 625 of 2,148 annual deliveries being to low-income women who find it almost impossible to obtain prenatal services within the county. This project aims to reduce the infant mortality rate in Jackson County by establishing a maternal and infant health care clinic to provide a full range of prenatal, postpartum and infant care services.

Partnership Project. *(Health Start, Inc., St. Paul, Minn.)*

In order to facilitate development of secure mother-infant attachments and to minimize closely-spaced pregnancies, this project will provide such services as case management, home visits, pediatric health care, support groups, and nutrition and family planning services.

First Steps Primary Prevention Program *(Louisiana Council on Child Abuse, Inc., Baton Rouge, La.)*

This project aims to develop healthy environments to promote nurturing relationships between parents and their children. Community volunteers will be trained to make hospital-based visits to new mothers to provide support and educational services during their postpartum hospital stays. Families assessed as being at high risk for child abuse and neglect will be served by home visitation teams.

The Family Growth Center Pilot Project *(Allegheny General Hospital, Department of Pediatrics)*

Using an integrated, primary prevention approach to promote the health and development of at-risk teen and young parents and their children, this project aims to increase social supports and enhance parenting abilities by providing hospital-based coaching.

Improving Health Status for Foster Care Children *(Kids Adjusting Through Support, Inc., Rochester, N.Y.)*

This project will develop support groups for foster care children and their parents. Foster care parent groups will meet simultaneously to assist parents in dealing with issues including child behavior, limit-setting, value systems and forming attachments with their foster children. A minimum of 50 foster families will be served per year.

Project First Step: A Family-Focused Program for Improving the Health Status of Low Birthweight Infants in Dallas County *(Parkland Memorial Hospital, Dallas)*

The goal of this project is to reduce infant mortality and morbidity in targeted areas of Dallas County by improving the health status of medically indigent and low birth weight infants. Four geographically targeted low birth weight clinics will be established and clinic staff will work with other programs to ensure that all eligible infants have access to health care.

Rural Partnership for Children *(The University of Nebraska Medical Center, Department of Pediatrics, Omaha, Neb.)*

A pilot rural pediatric consultation service will be developed and implemented in northwest Nebraska. The service will consist of six physicians who will see children with chronic or recurrent illnesses who have been referred by local providers and will confirm diagnoses, verify optimal treatments, and develop comprehensive, coordinated health care plans for the children and their families.

Collaborative Developmental Clinic *(Michigan State University, Department of Pediatrics and Human Development, East Lansing, Mich.)*

In order to coordinate care for children with behavioral and developmental problems, this project plans to design a system that will bring together the pediatrician, child psychologist and school consultant in a clinic that will comprehensively evaluate and offer treatment for the parents and child.

Healthy Children

An overview of nine model programs

School-based Primary Care *(Cambridge, Mass.)*

This was the original Healthy Children model in which health clinics are staffed by nurse practitioners and consulting pediatricians in local Cambridge community schools.

Social Enrichment and Primary Care for Preschool Children *(Great Barrington, Mass.)*

Preschool children in rural America frequently live in social isolation, lacking primary health care. Great Barrington solved this problem by establishing health clinics in schools, town halls, and other convenient locations, and by sponsoring play groups for children.

Teenage Pregnancy *(St. Paul, Minn.)*

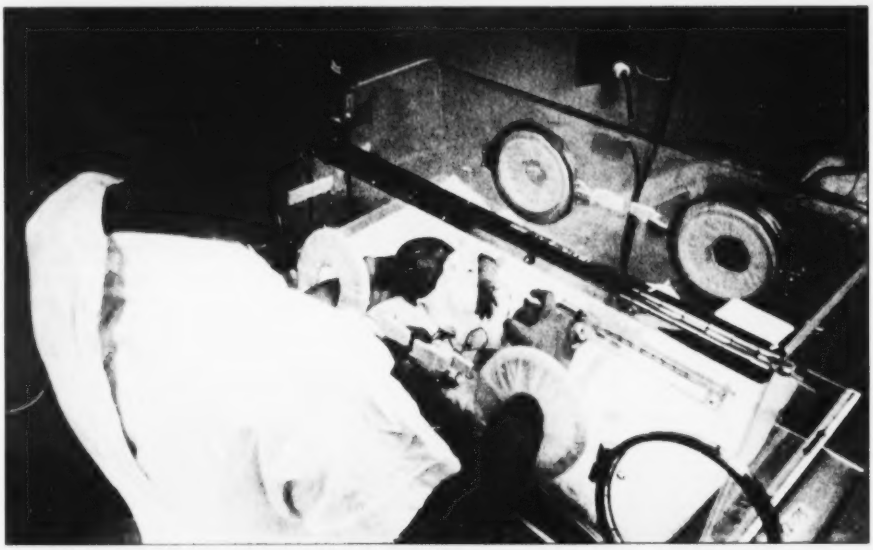
This pioneering program confronted the problem of teen pregnancy by placing multi-disciplinary health clinics in local high schools and emphasizing family planning along with other health services. In addition, day care services are provided to encourage teen mothers to remain in school.

Comprehensive Primary Care for Mothers and Children *(Sarasota, Fla.)*

Urban and rural children who do not have access to a pediatrician overuse hospital emergency wards or go without necessary services. In Sarasota County, the public health department provides 24-hour, seven-day-a-week coverage for those youngsters under the terms of a unique agreement between the public health department and pediatricians in private practice.

Handicapped Children in Rural America *(Gainesville, Fla.)*

Handicapped children in rural America are medically and geographically isolated. Gainesville solved this problem by dispatching circuit-riding nurses to the homes of handicapped children where they provide otherwise unattainable care.



States Acting as Foundations *(Oregon)*

The Oregon model is a financial solution model. Multnomah County, which includes Portland, faced two principle problems among its school population: inadequate medical care for some and a growing teen pregnancy problem. Combining both the Cambridge and the St. Paul approach, county commissioners allocated limited funds to open a clinic in one Portland high school. Spurred by this experience, the state legislature appropriated funds to enable the state health department to issue a request for funding proposal; now, nine Oregon high schools have school-based clinics.

Reorganinzing Public Health Bureaucracies *(Waycross, Georgia)*

In rural Waycross, an imaginative pediatrician and public health director broke down the walls of the state's public health bureaucracy. They combined four separate public health clinics for children into a single new Teen Clinic centrally located that provides well child care, mental health services, services for children with disabilities and regular outpatient clinic care. The group recently has expanded its clinic services into other high schools, as well.

Handicapped Children in Urban America *(Chicago and San Diego)*

This approach transfers the Gainesville, Florida, model for handicapped children in rural America to urban settings. Responsibility for case management of a panel of handicapped children is centered in local children's hospitals in both Chicago and San Diego. As in Gainesville, nurses circuit-ride to patients' homes treating problems there, thus avoiding costly visits to tertiary level facilities.

Independent Taxing Districts for Children *(Palm Beach County/Pinellas County, Fla.)*

This is a financial model having enormous potential. Based on an approach pioneered 40 years earlier in Pinellas County, Palm Beach County passed a referendum in 1986 to create an Independent Taxing District for Children. This legislation, made possible by a new Florida statute enabling any county to do the same, levies a tax on property owners in Palm Beach County. The tax proceeds are used to fund and operate a Children's Services Council. Two other Florida counties — Hillsborough and Martin — have passed similar referenda. Palm Beach County alone has a potential income stream of $18 million per year.

Public awareness efforts

Overcoming information barriers

Picture a child in a stroller. Imagine wheeling the child into a department store to do some shopping. But before you shop, you leave the child and the stroller near the doorway. You walk away.

You don't worry.

You don't think twice about doing this.

You know that other adults coming into the store will stop and tend to your child if he becomes fussy. You know you will do the same for their children.

This is a scene that happens again and again, time after time, in Denmark. It doesn't happen in the United States.

The Academy is developing a major public awareness campaign to overcome the information barriers that families face.

In its broadest sense, the public awareness campaign will seek to spread the word that each of us is responsible for every child.

"We don't look at the needs of our children as a nation's needs," says former AAP President Birt Harvey, M.D. "We must change our philosophy toward children in this country."

Changing long-held, fundamental attitudes about protecting children may not be easy. For instance, parental leave legislation has been discussed — but not enacted — for about five years.

Still, pediatricians point to a number of reasons for striving toward that change. In part, making children a priority will help ensure that American children grow into healthy, educated and effective competitors in a global business market.

But Dr. Harvey notes a more basic reason, as well: "We need to do this on moral grounds," he says.

The AAP public awareness campaign also will seek to help parents and children make better use of available health care services.

In 1986, Florida state legislators passed the Child Health Assurance Act, which required insurance companies to provide preventive health coverage to insured depedents up to age 16 years. A report released earlier this year by the Florida Department of Insurance examined increases in insurance premiums and utilization of services since the law was passed. According to the report, the law has not caused the vast majority of private insurers to increase premiums. However, one reason for the low cost might be low utilization.

Florida pediatricians cite several possible reasons for low utilization, including: miscoding of insurance forms, the resistance by some insurance companies to recognize the law, loopholes in the law and the complex nature of insurance in general.

In turn, the Florida Department of Insurance and the state's Department of Education have launched a pilot project to educate parents through the schoolroom about the health assurance act. Under the education program, children are given information in the classroom to take home and share with their parents.

The program is just one of perhaps countless programs that might work locally to increase utilization; for as Dr. Harvey, notes, "Ensuring access to care does no good if that care isn't used."

For additional information about AAP public awareness efforts, contact: AAP Department of Communications, P.O. Box 927, 141 Northwest Point Blvd., Elk Grove Village, IL 60009-0927; (800) 433-9016.

AAP public awareness efforts will seek to make children's needs our nation's needs — and encourage families to make better use of existing health care services.

American Academy of Pediatrics

The American Academy of Pediatrics is an organization of 40,000 pediatricians dedicated to improving the health, safety and well-being of infants, children, adolescents and young adults.

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AAP Special Report: Solutions

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